

Fella's Family Project

Male Family Worker

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Ballina NSW

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REFERRAL

Criteria: The male who the service is requested for must:

- Be a father with dependant children
- Live in the Ballina or Byron Shires

Date of Referral: _____

Client Number _____

Client aware of referral **YES/NO**

REFERRAL FROM:

Name/Position: _____

Agency/Service: _____

Phone No: _____ **Fax No:** _____

Email: _____

PARENT'S DETAILS:

Parent/Carer: _____

D.O.B: _____

Address: _____

Phone: _____

PARENT'S DETAILS:

Parent/Carer: _____

D.O.B: _____

Address: _____

Phone: _____

ATSI: Yes / No

CALD : Yes / No

Family structure: (eg. Blended, Single etc..) _____



CHILDREN:				
First Name	Surname	Female/Male	DOB / Age	Living with

Brief outline of presenting issues: _____

CHILD PROTECTION:

Concern for safety of Children ? Yes No

Has DoCS been notified ? Yes No

Date of report to DoCS _____

Current court orders Yes No

Detail of current orders: _____

WORKER INFORMATION:

Any safety issues? _____

Other Agencies Involved? _____

